STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155472		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/06/2012	
	PROVIDER OR SUPPLIE	R	9875 C	ADDRESS, CITY, STATE, ZIP CODE CHERRYLEAF DR NAPOLIS, IN 46268	
(X4) ID PREFIX TAG K0000	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	State Licensure the Indiana State accordance with Survey Date: 0 Facility Number Provider Number AIM Number: Surveyor: Mark Code Specialist At this Life Safet Village was four Requirements for Medicare, 42 C. Life Safety from of the National Association (NI Code (LSC) and original building Chapter 19, Expocupancies. This one story for the Story for the National Association (NI Code (LSC) and original building Chapter 19, Expocupancies. This one story for the of Type V (1) fully sprinklered alarm system was resident sleeping.	r: 000548 er: 155472 NA c Caraher, Life Safety ety Code survey, Hoosier and not in compliance with or Participation in FR Subpart 483.70(a), an Fire and the 2000 edition	K0000	This plan of correction constitute written compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This of correction is submitted to not the requirements established the state and federal law.	t plan neet

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/06/2012		
	PROVIDER OR SUPPLIER R VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE COMPLET	ION	
	doors. The facility has a capacity of 122 and had a census of 70 at the time of this survey.					
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FGB821

Facility ID: 000548

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	ETED
		155472	B. WIN			02/06/	2012
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY) E		DATE
K0018 SS=E	than required enclopenings, exits, or substantial doors, of 1¾ inch solid-be capable of resistin minutes. Doors in only required to re There is no imped doors. Doors are suitable for keepin doors meeting 19. 19.3.6.3 Roller latches are regulations in all h Based on observation facility failed to come corridor defirame. This defires	shazardous areas are such as those constructed onded core wood, or g fire for at least 20 sprinklered buildings are sist the passage of smoke. iment to the closing of the provided with a means g the door closed. Dutch 3.6.3.6 are permitted. prohibited by CMS ealth care facilities. ation and interview, the ensure 1 of 61 resident poors latched into the door client practice could int, staff or visitor in the	K00	018	1.There were no residents affected. 2.Immediately following the inspection on 2/6/12, the latch mechanism for the door to resident room 208 was adjuste and functioning properly. All	_	02/16/2012
	Findings include Based on observation before the facility from on 02/06/12, the the corridor door failed to latch the frame. Based on observation, the Environmental S latching mechanifunctioning and a	ation with the Director of ervices during a tour of 12:30 p.m. to 2:55 p.m. latching mechanism for to resident Room 208 e door into the door interview at the time of			other doors were checked by t surveyor during the tour of the facility and found to be latching appropriately. Therefore, no of doors were affected. 3.As a means of ongoing compliance, quarterly safety inspections will include checking each resident door to ensure to the latching mechanism is working properly. 4.As a means of quality assurance, results of those monthly safety inspections will reviewed during the quarterly Safety Committee meetings.	g her ng hat	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FGB821

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155472	LDING	<u>01</u>	COMPL 02/06	ETED	
NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	to latch into the was closed.	door frame when the door					
	3.1-19(b)						

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Event ID: FGB821

Facility ID: 000548

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
		155472				02/06/	/2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HOOGE	27/11/14/05				HERRYLEAF DR		
HOOSIEI	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
K0048		plan for the protection of all					
SS=E		eir evacuation in the event					
ļ	of an emergency.		ļ				
	Based on record	review and interview, the	K00)48	1. There were no residents		02/24/2012
	facility failed to	include the use of kitchen			affected. 2. Hoosier Village ha		
	fire extinguishers	s in 1 of 1 written fire			written plan stating procedures be followed in the event of a file		
	safety plans for t	he facility. LSC 19.7.2.2			emergency. Periodic staff	C	
	. –	health care occupancy			rehearsals include fire		
	•	shall provide for the			extinguisher demonstrations.		
	following:	shall provide for the			Further, the kitchen overhead		
	(1) Use of alarms				hood extinguishing system		
	` '				automatically activates with he		
	. ,	of alarm to the fire			sensors. Therefore, there were no other residents with the	;	
	department				potential to be affected. 3.The		
	(3) Response to a				Fire Plan has been revised to		
	(4) Isolation of fi	ire			state that activation of the		
	(5) Evacuation of	f immediate area			overhead hood extinguishing		
	(6) Evacuation of	f smoke compartment			system must occur before usir	ng	
	(7) Preparation o	f floors and building for			the ABC or the K class fire		
	evacuation	C			extinguisher to extinguish cool line fires. 4.Training for kitcher		
	(8) Extinguishme	ent of fire			staff to activate the overhead f		
	· · · · · · ·	actice affects any			extinguishing system to suppre		
	_	d visitors in the vicinity			a cook line fire before using ei		
	· ·	u visitors in the vicinity			the ABC or the K class fire		
	of the kitchen.				extinguisher will be completed		
					2/24/2012. All new kitchen star	Ħ	
	Findings include	:			will receive training on the activation of the hood system		
					during his/her orientation.		
	Based on a revie	w of the facility's written			daming morner offernation.		
	fire safety plan ti	tled "Disaster Plan: Fire					
		ord review with the					
	_	ronmental Services from					
		5 a.m. on 02/06/12, the					
		id not address the use of					
		tinguishers and the K					
	class fire extingu	isher located in the					
			1		l		1

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Event ID: FGB821

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PRINTED: 02/27/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/06/2012		
	PROVIDER OR SUPPLIER R VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
	kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Director of Environmental Services acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher. 3.1-19(b)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FGB821

Facility ID: 000548

If continuation sheet

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155472	A. BUILDING	01	COMPLETED 02/06/2012
		100712	B. WING	ADDRESS CITY OF THE CITY COST	02/00/2012
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE	
HOOSIEI	R VILLAGE			NAPOLIS, IN 46268	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG K0064		LSC IDENTIFYING INFORMATION) guishers are provided in all	TAG	DEFICIENCI)	DATE
SS=E	health care occup	ancies in accordance with 6, NFPA 10			
	i	ation and interview, the	K0064	1.There were no residents	02/13/2012
	facility failed to	maintain 1 of 1 portable		affected.	£
	K class fire extin	nguishers in the kitchen		2.A placard stating that the protection system shall be	tire
	cooking area in a	accordance with the		activated prior to using the fire	e
	requirements of	NFPA 10, Standard for		extinguisher was conspicuous	sly
	Portable Fire Ext	tinguishers, 1998 Edition.		posted on the wall directly about the K along fire extinguisher a	
	NFPA 10, 2-3.2	requires fire		the K class fire extinguisher on 2/13/2012. Therefore, there is no potential for other residents to be	
	extinguishers pro	ovided for the protection			
of cooking appliances using comb cooking media (vegetable or anim	ances using combustible		affected.		
	cooking media (v	vegetable or animal oils		3.Monthly inspection of the	
	and fats) shall be	e listed and labeled for		class fire extinguisher will incl that the required placard is in	uae
	Class K fires. N	FPA 10, 2-3.2.1 requires		place. A tag will be dated and	
	a placard shall be	e conspicuously placed		initialed at the time of inspect	
	near the extingui	sher which states the fire		4.Quarterly inspections by t	he
	protection system	n shall be activated prior		safety committee will include visualization of the placard in	
	to using the fire	extinguisher. Since the		place.	
	fixed fire extingu	aishing system will			
	automatically sh	ut off the fuel source to			
	the cooking appl	iance, the fixed system			
	should be activat	ted before using a			
	portable fire exti	nguisher. In this			
	instance, the port	table fire extinguisher is			
	supplemental pro	otection. This deficient			
	practice could af	fect any residents, staff or			
	visitors in the vic	cinity of the kitchen.			
	Findings include	:			
		ation with the Director of			
		ervices during a tour of			
	the facility from	12:30 p.m. to 2:55 p.m.			

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PRINTED: 02/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155472	A. BUILDING B. WING	01 	COM	PLETED 06/2012
	PROVIDER OR SUPPLIER		9875	ET ADDRESS, CITY, STATE, ZIP 5 CHERRYLEAF DR IANAPOLIS, IN 46268	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	portable fire extifire protection syprior to using the extinguisher. Batime of observation Environmental Splacard was not near the K class stating the fire protection of the extinguisher.	aced near the K class nguisher which states the extem shall be activated ext class portable fire used on interview at the ston, the Director of ervices acknowledged a conspicuously placed portable fire extinguisher rotection system shall be o using the K class				

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Event ID: FGB821

Facility ID: 000548

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 COMPL			COMPLE	TED
		155472	B. WIN			02/06/2	.012
			p. ,, 12,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				HERRYLEAF DR		
HOOSIEI	R VILLAGE				APOLIS, IN 46268		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification and	 K00)00	This plan of correction constitu	ıtes	
	_		Koc)OO	the written compliance for the		
		Survey was conducted by			deficiencies cited. However,		
		Department of Health in			submission of this plan of		
	accordance with	42 CFR 483.70(a).			correction is not an admission		
	Survey Date: 02.	/06/12		that a deficiency exists or the one was cited correctly. This of correction is submitted to			
	Facility Number:	000548			the requirements established the state and federal law.	ру	
	Provider Number	r: 155472					
	AIM Number: N	JA					
	Surveyor: Mark	Caraher, Life Safety					
	Code Specialist	•					
	1						
	At this Life Safet	ty Code survey, Hoosier					
		d not in compliance with					
	Requirements for	_					
	•	R Subpart 483.70(a),					
		* * * * * * * * * * * * * * * * * * * *					
	1	Fire and the 2000 edition					
	of the National F						
	`	PA) 101, Life Safety					
	Code (LSC) and	410 IAC 16.2. The					
	nurses station nea	ar resident Room 128					
	and Room 129 w	vas constructed in 2010					
		d with Chapter 18 New					
	Health Care Occi	-					
		ирипотов.					
	The 2010 addition	on to the one story facility					
		to be of Type V (111)					
		was fully sprinklered.					
		a fire alarm system with					
	smoke detection	in resident sleeping					

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Event ID: FGB821

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PRINTED: 02/27/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155472		A. BUILDING B. WING (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 02/06/2012			
	PROVIDER OR SUPPLIER R VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	rooms, support rooms and at smoke barrier and horizontal exit doors. The facility has a capacity of 122 and had a census of 70 at the time of this survey.					
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:					

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Event ID: FGB821

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING		02	COMPL	ETED
		155472	A. BUILDING			02/06/	2012
			B. WING	DDT 4	DDDEGG GVEV GELTE JUD GODE		
NAME OF F	ROVIDER OR SUPPLIER	R			DDRESS, CITY, STATE, ZIP CODE		
					HERRYLEAF DR		
HOOSIEI	R VILLAGE		INL	DIANA	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			IE.	DATE	
K0046 SS=E		ng of at least 1½ hour ed in accordance with 7.9.					
,	i	review, observation and	K0046	1	1.There were no residents	1	02/16/2012
		cility failed to ensure	10010		affected.		02/10/2012
	· ·	ing was provided in			2.A functional test with		
					documentation was conducted		
		LSC 7.9 for 2 of 2			the 2 battery powered emerge	ncy	
		emergency lights for 12			lighting systems on 2/17/12.	_	
	of 12 months. L	SC 7.9.3 Periodic Testing			Further, the emergency lighting systems are on the back up	y	
	of Emergency L	ighting Equipment			generator.		
	requires a functi	onal test to be conducted			3.As a means of ongoing		
	-	als and an annual test to			compliance, Hoosier Village w	vill	
	1	every required battery			perform a functional test		
		ency lighting system for			every month and annual tests		
		2 -hr duration. Equipment			no less than a 90 minute durat	tion	
					on the 2 battery powered		
		erational for the duration			emergency lighting systems to ensure equipment is fully)	
		ten records of visual			operational. Written records w	/ill	
	inspections and	tests shall be kept by the			be maintained.	, iii	
	owner for inspec	ction by the authority			4. As a means of quality		
	having jurisdicti	on. This deficient			assurance, monthly safety		
		ffect any resident, staff or			inspections will be reviewed w	ith	
	•	inity of the facility exit by			the Safety Committee during		
		on near resident Room			quarterly meetings		
		on near resident Room					
	128.						
	Findings include	:					
	Based on record	review with the Director					
		al Services from 9:30 a.m.					
	to 11:35 a.m. or						
		· · · · · · · · · · · · · · · · · · ·					
		of functional testing of					
		emergency lights at 30					
	day intervals and	d an annual test of battery					
	powered emerge	ency lights in the facility					
			1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155472	A. BUILDING 02 B. WING	COMPLETED 02/06/2012				
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CORRECTION SHOULD BE CROSS-REFERENCED.	(X5) COMPLETION DATE				
	was not available for review. Based on observation with the Director of Environmental Services during a tour of the facility from 12:30 p.m. to 2:55 p.m. on 02/06/12, a battery powered emergency lighting system was observed inside the building at the facility exit by the nurse's station near resident Room 128 and a battery powered emergency lighting system was observed inside the nurse's station office near resident Room 128. Based on interview at the time of observation, the Director of Environmental Services stated documentation of monthly and annual testing of each battery powered emergency light was not maintained and acknowledged no documentation of monthly and annual testing of each battery powered emergency light was available for review. 3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FGB821

Facility ID: 000548

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